Medicus Pain and Spine, PLC
Personalized Pain Care

Richard K. Nadjarian, M.D., M.P.H.

Bloomfield Hills
36880 Woodward Ave., Ste 220
Bloomfield Hills, MI 48304-0920
P: 248-594-7900 | F: 248-792-3642

Canton
44633 Joy Rd., Ste 200
Canton, MI 48187-1730
P: 734-446-0337 | F: 248-792-3642

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Dr. Patient,

Thank you for scheduling a New Patient appointment with Dr Richard Nadjarian. In order to facilitate your new visit, please complete the New Patient forms and bring them with you to your visit.

In this packet, please complete pages 1-6 and 8-10 before your appointment. The first page is general information for registration purposes and the pages that follow provide Dr. Nadjarian with your medical history and other pertinent information for Dr Nadjarion to complete a thorough evaluation of your condition. It is best to wait until the night before to complete the pain and symptom questions so that the descriptions most accurately reflect your current condition.

You will also need to bring your **Picture ID, Insurance card, and (if pertains) a referral from your Primary Care Physician**, a prescription with diagnosis from the doctor referring you to our office, and **test result reports** (MRI's, CT Scans, EMG's, etc.)

Please note that Copays, Co-Insurance and Deductibles are due at the time of services no exceptions. Also, we appreciate a 24 hour notice if you cannot keep this appointment to be able to offer it to another patient in pain.

We look forward to meeting you and having the opportunity to participate in your care.

Appreciatively,

Richard Nadjarian MD and Staff
Medicus Pain and Spine

APPOINTMENT DAY AND TIME_____

LOCATION: _____

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Temp:_____ Pain :_____

Demographic Information

Name:_____Date of Birth:_____

Social Security#:_____ Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Other

Address:_____
Street City Zip

E-mail Address:_____

Employer:_____Driver's License#:_____

Home Phone:_____Alternate Number:_____Work Number:_____

Race/Ethnicity: Alaskan American Indian Asian Black Hispanic Pacific Islander White Other_____

Language spoken: English _____Other_____

Emergency Contact Information

Name:_____Relationship:_____

Address:_____
Street City Zip

Home Phone:_____Alternate Number:_____

Insurance Information

Please give card(s) to front desk along with your picture identification card or driver license

Physician Information

Primary Care Physician:_____

Address:_____Phone Number:_____

Referring Physician:_____

Address:_____Phone Number:_____

Walk in Pharmacy:_____City:_____Phone Number:_____

I understand that there is no guarantee that I will be given any medications and there is no guarantee that I will be accepted as a patient in the practice.

I hereby authorize payment of medical benefits directly to the attending physician for services rendered. Authorization is hereby granted to release information as may be necessary to process and complete my claim. I understand I am financially responsible for this account.

Signature:_____ **Date:**_____

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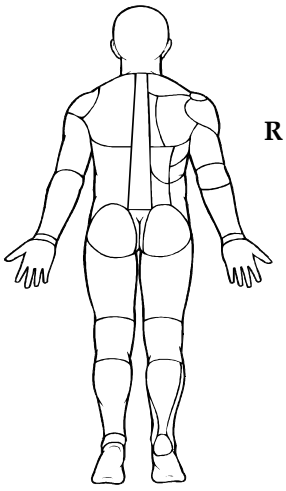
Initial Patient Assessment Form

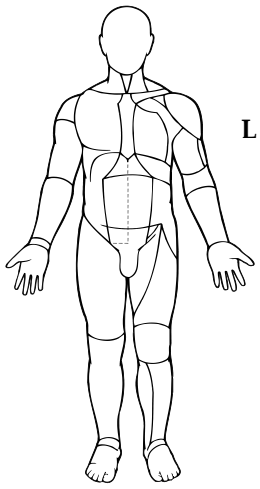
Name: _____ Age: _____ Visit Date: _____

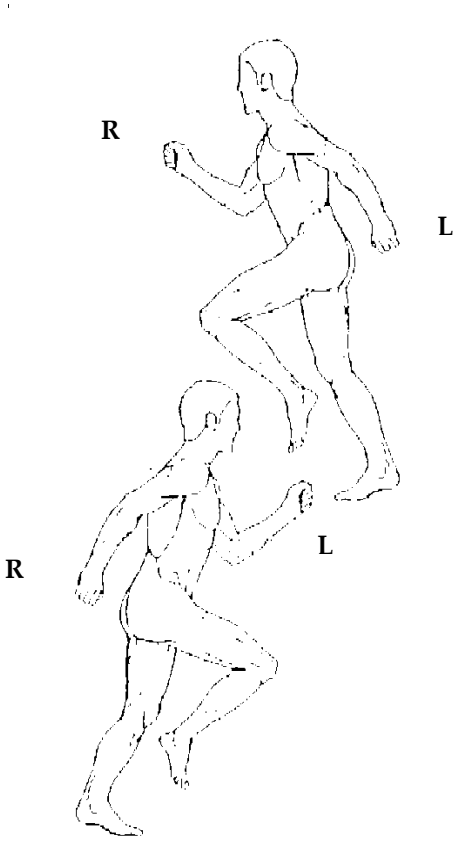
What is the main reason for your visit to the doctor today?

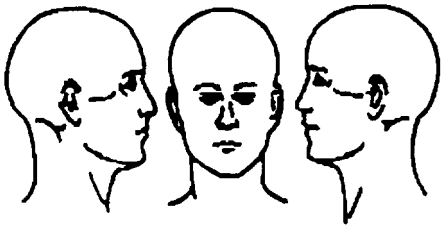
_____

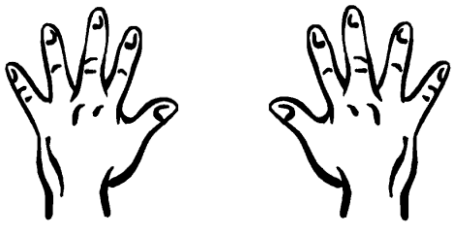
Draw an "X" on the figure below showing where your pain starts and an arrow showing where it goes.











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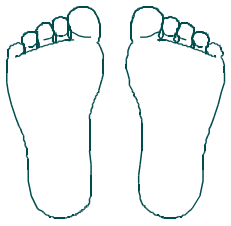

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DESCRIBE WHEN AND HOW YOUR PAIN STARTED BELOW:

1. Did the pain start_____? □ Gradually □ Suddenly

2. How long have you had this pain? _____days _____weeks _____months ____years

3. What were you doing when the pain first started?

_____

_____

4. Have you had this pain in the past? □ No □ Yes
   If yes, when did the pain first start? _____

5. Is the pain_____? □ Constant □ Intermittent

6. Does the pain occur at specific times of the day? □ No □ Yes
   If yes, please explain: _____

DESCRIBE THE QUALITY OF YOUR PAIN BELOW:

My pain feels like it is (circle those that apply)…

Throbbing	Sharp	Hot-Burning
Shooting	Cramping	Aching
Stabbing	Gnawing	Dull

DESCRIBE THE INTENSITY OF YOUR PAIN BELOW:

1. Describe your pain at its **WORST**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

2. Describe your pain at its **BEST**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

3. Describe your pain on **AVERAGE**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

4. What makes the pain worse? Circle all that apply.

bending forward	coughing	prolonged standing
bending back	sneezing	prolonged sitting
lifting	changing position	running
urinating	walking	sexual intercourse
defecating	lying down	stress

If the above do not apply, please describe what makes your pain worse:

_____

_____

5. What makes the pain better? Circle all that apply.

heat	walking	lying down
ice	standing	changing position
medication	sitting	resting

If the above do not apply, please describe what makes your pain better:

_____
_____

6. Are there other symptoms associated with the pain? Circle all that apply.

difficulty sleeping depression loss of appetite fever weakness

TREATMENT HISTORY

1. Which of the following types of providers have you visited prior to your arrival here?

□ primary care physician	□ orthopedic surgeon	□ physical medicine & rehab
□ rheumatologist	□ neurosurgeon	□ neurologist
□ anesthesiologist	□ chiropractor	□ acupuncturist

□ other: _____

2. Which of the following tests have you undergone prior to your arrival here?

□ x-ray	□ CT scan	□ MRI scan
□ discogram	□ myelogram	□ diagnostic neural block
□ EMG	□ bone scan	□ diagnostic ultrasound

□ other: _____

3. What medications have you taken for your pain in the past?

_____

4. Which of the following treatments have you had for your pain prior to your arrival here?

□ epidural steroid injections	□ therapeutic ultrasound
□ trigger point injections	□ TENS/nerve stimulator
□ facet joint injections	□ physical therapy
□ medial branch blocks	□ cryotherapy (cold therapy)
□ sacroiliac joint injections	□ therapeutic heat
□ radiofrequency ablation	□ biofeedback

□ other: _____

5. Has your pain resulted in any of the following?

□ bed rest	□ loss of function	□ worker's compensation
□ loss of work	□ litigation	□ hiring an attorney

If any of the above applies, please explain in further detail:

_____
_____

CURRENT MEDICATIONS (please use a separate sheet if needed)

Name	Dosage	How Often	Name	Dosage	How Often

DRUG ALLERGIES and reactions:

_____

PAST MEDICAL HISTORY:

_____

PAST SURGICAL HISTORY with dates:

_____

FAMILY HISTORY

Mother: □ Living Age _____ □ Deceased
Health issues while alive: _____
Father: □ Living Age _____ □ Deceased
Health issues while alive: _____

SOCIAL HISTORY

1. Do you currently smoke? □ No □ Yes, _____ packs/day _____years
   If no, have you smoked in the past? □ No □ Yes, ___year quit ___packs/day ___years

2. Do you currently use alcohol? □ No □ Yes, _____drinks/day ____drinks/week
   If no, have you used alcohol in the past? □ No □ Yes, _____ year quit

3. Do you currently use recreational drugs? □ No □ Yes, type(s) _____

4. Education: □ Grade School □ High School □ College □ Post-Graduate □ Vocational

5. What type of work do you do? _____

6. Have you ever had exposure to toxic/poisonous substances at work or home? □ No □ Yes
   If yes, please explain: _____

7. Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

CHILDHOOD HISTORY OF EMOTIONAL TRAUMA Mark all that apply.

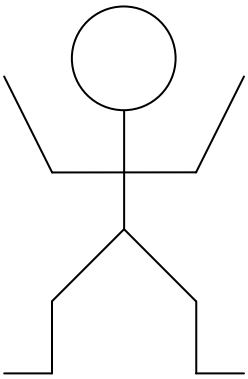
□ Physical Abuse
□ Sexual Abuse
□ Emotional abuse/neglect
□ Alcohol or drug use by caregivers

REVIEW OF SYSTEMS

Please circle the symptoms you are currently experiencing in each category. ***If no problems circle "No Problems"***

Constitutional	fever	weight loss	fatigue
No problems	loss of appetite	weight gain	night sweats
Cardiovascular	chest pain	palpitations	fainting spells
No problems	leg swelling		
Respiratory	trouble breathing	chronic cough	coughing blood
No problems	shortness of breath		
Gastrointestinal	nausea/vomiting	heart burn	loss of bowel control
No problems	diarrhea	constipation	blood in stool
Genitourinary	loss of bladder control	pain on urination	blood in urine
No problems			
Musculoskeletal	muscle cramps	joint pain	joint swelling
No problems	loss of muscle bulk	muscle twitches	
Dermatologic	rash	nail changes	sweating changes
No problems	hives	skin discoloration	itching
Neurologic	headaches	memory loss	seizures
No problems	weakness	tremors	
Psychiatric	hallucinations	high stress levels	inappropriate crying
No problems	suicidal thoughts		
Hematologic/Lymphatic	abnormal bleeding	abnormal bruising	swollen glands
No problems			

PLEASE DO NOT WRITE BELOW THIS LINE



Neck: nl_____

_____

Lungs: nl_____

Heart: nl_____

Mscsktl: nl_____

_____

_____

_____

Back/Pelvis: nl

Palpation: nl_____

_____

Sacroiliac: nl_____

_____

ROM: flex nl _____

ext nl _____

Neurologic: nl

T: R + - L + - H: R + - L + -

Strength: nl_____

Sensation: nl_____

Other: _____

_____

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HIPPA and Agreement Form

Notice of Privacy Practices Acknowledgement:

_____ Initial — I hereby acknowledge that I have been offered and/or received the Notice of Privacy Practices with which Medicus Pain and Spine, PLC complies.

Agreements:

_____ Initial **Assignments of Medical Benefits**

I understand that Medicus Pain and Spine, PLC will bill my insurance as a courtesy but ultimately, I am responsible for the entire cost of my care. I assign all rights and benefits to Medicus Pain and Spine, PLC in order to facilitate reimbursement for health care services. I will help Medicus Pain and Spine, PLC follow up on these claims. I agree to reimburse immediately for insufficient fund checks along with a $30 fee.

If collection efforts become necessary, I understand and agree that I will be responsible for the cost of collection of all unpaid amounts, including any administrative fees, billing fees, collection fees, attorney fees and court costs.

_____ Initial **General Consent to Receive Health Care Services**

I agree to receive health care services such as medical, dental, psychological, nursing, and/or other health care, which may include procedures, tests, drugs and treatment necessary to my care. I know that I have a right to discuss my care with a health care provider and that I have the right to consent or refuse to consent to any future care. My health care provider will discuss specific care/interventions including procedures with me and may obtain a specific consent. Invasive procedures and special treatments, such as immunizations or blood product administration, require specific consents. I know that the practice of medicine is not an exact science and outcomes may be different for each patient.

Patient Name: _____ DOB: _____/_____/_____

_____ _____
Patient/Parent/Legal Guardian Signature — Date

_____ _____
Witness Signature — Date

_____
Witness Printed Name

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Notice of Privacy Practices Sharing Acknowledgement:

I hereby acknowledge that I have been offered and/or received the Notice of Privacy Practices with which Medicus Pain and Spine, PLC complies.

_____ By initialing, I **DO** want my protected Health Information shared with my spouse and/or family members listed below.

Name of person(s) _____Relationship:_____

_____Relationship:_____

_____Relationship:_____

_____Relationship:_____

_____ By initialing, I **DO NOT** want my protected Health Information shared with my spouse and/or family member.

Patient Name: _____ DOB: _____/_____/_____

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Patient/Parent/Legal Guardian Printed Name Relationship

_____ _____
Witness Signature Date

_____
Witness Printed Name

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Medical Health Release Authorization

I,_____ _____
(Print Patient's Name) (Address)

authorize_____
to release information contained in my patient records, including, as applicable: information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Consumer & Industry Services (MDCIS) (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency syndrome "AIDS", and AIDS related complex "ARC"), alcohol and drug abuse treatment information protected under the regulation in 42 Code of Federal Regulations, Part 2, psychological services and social services information including communication made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

1. Medicus Pain and Spine, PLC 36880 Woodward Ave, Suite 220 Bloomfield Hills, MI 48304

2. Specific information to be disclosed: _____

_____

3. I understand that I have the right to revoke this authorization at any time expect as noted below. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the appropriate department/facility that was authorized to release information. I understand that the revocation will not apply to information that has already been released in response to this authorization of where the facility has acted in reliance upon this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The right to revoke is also discussed in the Privacy Notice. Unless otherwise revoked, this authorization will expire one year after signature.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____ _____
Relationship to Patient Patient's Date of Birth Last 4 digits SS #

_____ _____
Witness Signature Date

_____
Witness Printed Name